MDR Tracking Number: M5-04-2205-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on March 15, 2004.

The IRO reviewed CPT Codes 95851, 97265, 97250, 97150, 97110, 99213, 99214, 99211-25, 97750, 98940, 98941, 98943, 97012, 97024, 97139, 99070, 97124 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

The CPT Codes 95851, 97265, 97250, 97150, 97110, 99213, 99214, 99211-25, 97750, 98940, 98941, 98943, 97012, 97024, 97139, 99070, and 97124 for dates of service 05/20/03 through 09/02/03 **were** found to be medically necessary. The CPT Codes 95851, 97265, 97250, 97150, 97110, 99213, 99214, 99211-25, 97750, 98940, 98941, 98943, 97012, 97024, 97139, 99070, and 97124 for dates of service 09/04/03 through 11/17/03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for CPT Codes 95851, 97265, 97251, 97150, 97110, 99213, 99214, 99211-25, 97750, 98940, 98941, 98943, 97012, 97024, 97139, 99070, and 97124.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

On June 25, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Code 97110 for date of service 05/02/03. The carrier paid $14.00 and denied as "F". Per Rule 133.307(g)(3)(B), relevant information was not submitted to support the services were rendered as billed. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(9)(b) SOAP notes documenting one-to-one supervision was note submitted. Additional reimbursement is not recommended.

- CPT Code 97250 for date of service 06/25/03. EOBs were not submitted by either party. Therefore the disputed CPT code will be reviewed in accordance with the 1996 Medicare Fee Guideline. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(C)(3) reimbursement in the amount of $43.00 is recommended.

- CPT Code 99213 for date of service 07/02/03. The submitted EOB shows payment of $48.00 was paid; however, the insurance carrier has not submitted convincing evidence,

i.e. a cancel check that the office visit was paid. Per the 1996 Medical Fee Guideline, E&M Ground Rule (VI)(B) reimbursement in the amount of $48.00 is recommended.

- CPT Code 95851 (3 areas) for date of service 07/14/03 denied as "D". According to the HCFA-1500 submitted by the healthcare provider, this code was billed for 4 different body areas. The insurance carrier denied the cervical ROM as "V", which was discussed by the IRO reviewer, and denied the thoracic, lumbar and shoulder ROM as duplicate billing. It is evident by the submission of the HCFA-1500 the range of motion for these areas were not duplicated. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(E)(4) reimbursement in the amount of $108.00 ($36.00 x 3) is recommended.

- CPT Code 99080 for date of service 11/11/03. The insurance carrier paid $76.60 and denied service as "F". Per Rule 133.106(f)(3) copies of reports or clinical notes are paid at $.50 per page. The requestor billed 227 pages, the carrier paid for 153 pages; therefore, additional reimbursement in the amount of $36.90 (227 x $.50 = $113.50 - $76.60) is recommended.

This Decision is hereby issued this 4th day of November 2004

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees outlined above as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;

- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);

- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 05/20/03 through 09/02/04 and 11/11/03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 4th day of November 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/MF/mf

Enclosure: IRO decision

May 26, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2205-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ------ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation who is familiar with the condition and treatment options at issue in this appeal. The ------ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 44 year-old male who sustained a work related injury on ------. The patient reported that while at work as a truck driver he was involved in a motor vehicle accident with his truck. Initial treatment for this patient's condition included a home exercise program and

medications. On 4/16/03 the patient presented to the treating doctors office where he underwent an evaluation that included x-rays of the left clavicle. The x-rays of the clavicle indicated a transverse fracture mid shaft of the clavicle, and that the medial aspect of the clavicle had moved superior while the lateral aspect had moved inferior. The treating diagnoses for this patient included displacement of lumbar intervertebral disc without myelopathy, lumbar sprain/strain, grade II, neck sprain/strain, grade II, thoracic sprain/strain, grade II, left fractured clavicle, and left rotator cuff sprain/strain, grade II. The patient has been treated with active and passive physical therapy. On 4/23/03 the patient was evaluated by an orthopedic surgeon and on 4/24/03 the patient was evaluated by a pain management specialist.

Requested Services

ROM measure, joint mobil, myofas rel, ther proc, ther exer, OV, phy perf mus test, CMT 1-2 Reg, 3-4 Reg, extraspinal 1+ Reg, mech tract, diathermy, eu unlisted ther proc, sup and mat, and mas ther from 5/20/03 through 11/17/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Office notes 4/16/03 – 11/17/03
2. MRI report 5/27/03

Documents Submitted by Respondent:

1. Office notes 6/16/03 – 1/26/04

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ------ physician reviewer noted that this case concerns a 44 year-old male who sustained a work related injury to his left shoulder, neck and back on ------. The ------ physician reviewer also noted that the patient sustained a fracture of the mid left clavicle. The ------ physician reviewer indicated that the patient received physical therapy treatments until 4/16/03. The ------ physician reviewer noted that the patient was then evaluated by orthopedics and returned for treatment with a pain specialist. The ------ physician reviewer also noted that the patient received extensive work hardening treatments focusing on his neck pain and range of motion, shoulder pain and range of motion, and back pain and range of motion. The ------ physician reviewer indicated that the patient showed some improvement in work capacity from 5/20/03 through 9/2/03. However, the ------ physician reviewer noted that after that period the patient experienced a decline in his condition. The ------ physician reviewer explained that the procedures and measurement performed from 5/20/03 through 9/2/03 were beneficial and resulted in improvement in this patient's condition. The ------ physician reviewer also explained that there was no improvement in this patient's condition after 9/2/03 and that there was a decline in work capacity documented. The ------ physician reviewer further explained that there were no range of motion measurements for the left shoulder and that the range of motion

measurements for the neck and back were within normal limits. Therefore, the ------ physician consultant concluded that the ROM measure, joint mobil, myofas rel, ther proc, ther exer, OV, phy perf mus test, CMT 1-2 Reg, 3-4 Reg, extraspinal 1+ Reg, mech tract, diathermy, eu unlisted ther proc, sup and mat, and mas ther from 5/20/03 through 9/2/03 were medically necessary to treat this patient's condition. However, the ------ physician consultant concluded that the ROM measure, joint mobil, myofas rel, ther proc, ther exer, OV, phy perf mus test, CMT 1-2 Reg, 3-4 Reg, extraspinal 1+ Reg, mech tract, diathermy, eu unlisted ther proc, sup and mat, and mas ther from 9/4/03 through 11/17/03 were not medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department